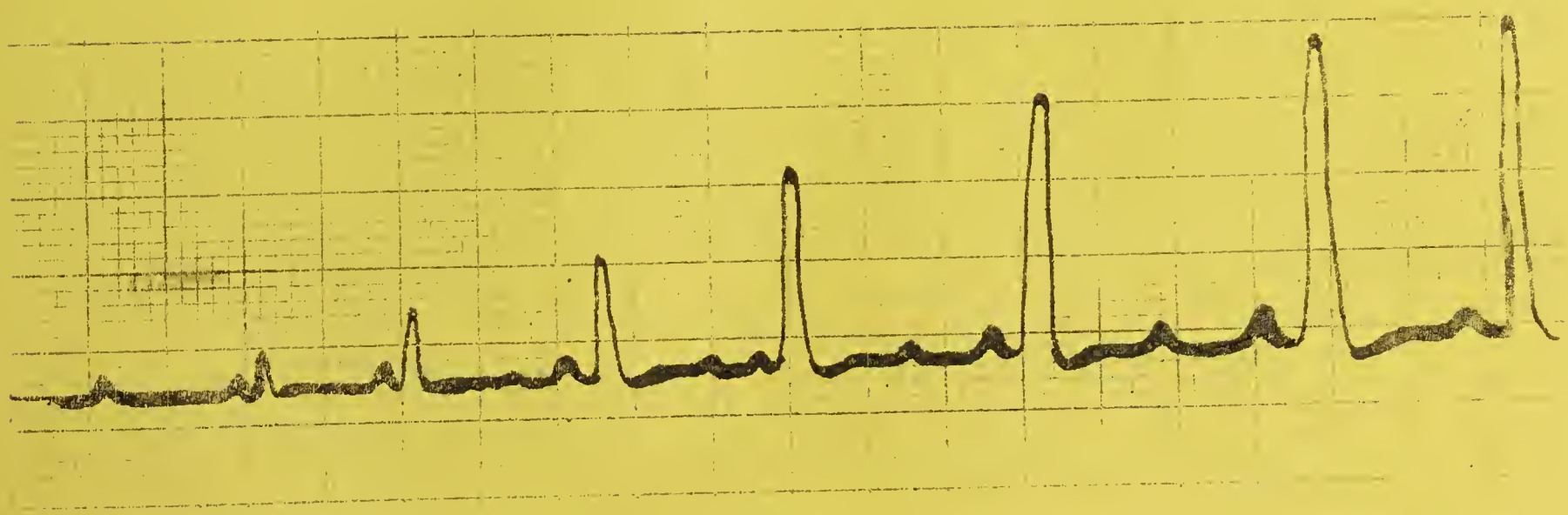
THE auricle

LIVES!



MAY '71

THE MEDICAL SOCIETY
UNIVERSITY OF TORONTO

THE AURICLE

MAY '71

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HAEC PUBLICATIS POSSIT VALERE PISCES MORTUUS AMICIRE

~ THE AURICLE ~

Editor - Rick Fisher, philosophe, bon vivant, literateur, and bike-freak.

With a little help from my friends:
Marion (last but not least) Hutt, Stephen (no arms) Ticktin, Bob (slicer) Moses, Crash Duggan, The highly esteemed, overworked Mrs. Lorimer, Gus Tetner and his entourage of mechanical gnomes, trolls and entelechies, N. Cephalus, a head of his time, The Delphic Oracle, and his weird messages from above.

With special thanks to the lively trio of Disease, Trauma, and Degeneration.

~ EDITORIAL ~

I was among the thirty-three people formerly from B. & M., who joined the Period IC class last November. We were greeted by the sight of our newly adopted class representatives urging the rest of the second year medical students to press on in the fight to remove the IC comprehensive soon to be unleashed upon them. I couldn't help thinking at that time that this, although an honourable cause, was a hopeless battle, lost from the outset. The Faculty had already made up its mind, most of the exam had been written; the die had surely been cast. This Goliath was just too mammoth to contend with.

But what did I know? I had just completed four years in the Faculty of Arts and Science, interested in only those issues close at hand; a lecture here, a project there. The machinery governing my education, what courses I took, what exams I wrote, was, in my mind, a nebulous, intangible, unreachable power. I was no guerilla fighter, no upsetter-of-the-apple-cart, for this power was too firmly entrenched, and after all, didn't they look after me? All that was required of me was to pay my fee to the man, mind my manners, and sure enough, in four years I received that piece of paper saying I was truly an educated man. They said, "Jump!" I said, "How high?" An old story.

The students were successful, as the IC comprehensive was cancelled. All those seemingly futile pleadings by the class representatives, exhorting my classmates to attend

the meetings, to express their feelings to the Department Heads had paid off.

It is important to note that this was not a power struggle between the students and the faculty merely for power, but rather students vocalizing a legitimate complaint with enough tenacity and stamina to be heard. This is how it has to be done.

Now I was interested. How much influence could students have as individuals or collectively in shaping the mould that was to shape them? Soon after, the bulky, unwieldy Faculty Council had an important meeting to consider proposals for trimming off a considerable amount of its own fat and becoming a much smaller, more efficient and functional body. All medical students stood to gain as our representation in the existing Faculty Council would be increased from a neglible percentage to a viable minority in the new framework. Again, I was astounded; out of the 300 or so faculty members there, representing all facets of the medical spectrum, none were more vociferous than three student representatives in getting the rest to adopt adequate proposals.

It was through these events that I became convinced that I could now have some say in the quality of education I would be receiving. It takes a willingness to work, but more important, the effort itself. Surprisingly enough, not that much effort is required, for the Faculty is not a coterie of ogres, but reasonable, flexible men when aroused from their initial aloofness.

* * *

The task I have undertaken as editor of this newly resurrected Auricle is to provide a means whereby we can see what our elected Assembly is doing. I hope that the Auricle can serve as a marketplace for our ideas on subjects either relevant or irrelevant to medicine. I think this magazine can fill some of the void left by the demise of the Probe; thus I encourage any literary attempts, short stories, poems, essays, scribblings, graffiti or whatever. Any organized opinions on our medical education, especially from people who normally don't write anything other than multiple choice examinations will be gladly accepted. Some articles in this magazine will be good, some will undoubtedly be poor, but at least they will be presented.

OUR PRESIDENT SPEAKS

There is no other way to begin other than to congratulate and thank Rick Fisher, 7T3, for taking on the difficult and essential job of rejuvenating the Medical Society by providing it with a potent and viable organ of communication. This publication is and has been called the Auricle, but I wonder whether the analogy could not more aptly be made with a more significant and pleasurable endowment of the human body. Some of you will remember the loss of our vital organ about a year ago when it was decided that the Auricle be scrapped for lack of funds. It was hoped that a cooperative effort with the Synapse, which is published by the staff, would suffice as an outlet for our frustrations, ideas and information. I was opposed to the idea then, but democracy prevailed and financial resources helped to dictate the situation. I mourned the loss of our ability to stand up for ourselves.

This first issue of the Auricle will serve, I feel, both as a stimulant and as a placebo, accompanied by other side effects as well. It will serve as a stimulant in making you aware of what the new Assembly is doing. As a result, it will, I hope, spur some of you on to ask questions and put pressure on your elected representatives. It will serve as a placebo to some, in that it will create the impression that the Assembly is energetically involved in making changes that you want, even though you may not have any idea at times of how effective (or ineffective) our efforts have been and will be. The side effects will vary from person to person, depending on what is agreeable and important to each one of you.

There are many problems facing the Faculty as a whole today. There have been sound ideas brought forward both for and against the new curriculum. Unfortunately, there are many staff men, especially in the hospitals, who have expressed what I think, is a rather severe cynicism towards the new curriculum. What is disturbing is not that they think that the "new" teaching is unsuitable, but that they would rather not contribute towards its success. They would prefer greater hospital autonomy in teaching, not for its own sake, but because they disagree with the ideals, thoughts and decisions which are emerging in the Faculty Council and the Dean's Office.

The aims of the Faculty as part of the University, are not all that clear, but undergraduate education would certainly be included as one of the top priorities.

The aims of the Faculty as seen by its Hospital participants, however, would not and I submit do not give undergraduate education the priority and attention it deserves. There may be many reasons for this and it would require a lot of time and space to discuss them. But I would submit that the amount of importance that your teachers attribute to you as undergraduates in any period will be proportional to the demands you make and the involvement you show in your education. If you remain satisfied with a half-assed lecture, then that's what you'll continue to get.

The excuse that medical students are too busy to get involved, even in improving their own educational processes or in evaluating them, is a lot of garbage. I'm sure that these people don't spend all their time buried under journals, books or assignments. The real reason is often that most medical students, although highly intelligent, have a very naive (not necessarily noble or idealistic) concept of their Faculty and of their education. They need to be told that part of their university career must consist of a critical analysis of its processes and an active participation in them. But as long as the staff and the senior classmen continue to propogate the idea of education being a ready-made ready-wrapped hand-me-down package, the syndrome of the apathetic medical student will persist.

Fortunately for us, there is a growing number of students who have become increasingly aware of the problems facing them. They have constructively participated in the various committees and in the extra-curricular activities available to them. They reached a point where they were able to bring about what was in effect, a reversal of a decision made by the Curriculum and Examinations Committee, the gathering of the gods. I think we should recognize that this type of flexibility is a credit to both students and the staff, and that it makes for better relationships in the future.

On the extra-curricular activities, Daffydil continues to flourish. This year's chairman, the wanton Paula Chalmers, is bound to accost every talent in the student body. Andy Osuszek has already produced one folk concert and has more on the way. His talents as an organizer and as an artist are exceptional so that we expect great things of him. The number of motorcycle enthusiasts (a direct index of interest in orthopaedics, masochism, the extra Y chromosome and sex appeal) continues to grow.

The number of virgin males has declined; the majority of them will graduate next year and improve statistics considerably. Contrary to popular belief, the number of virgin females in the class of 7T2 is not increasing. The idea may be related to the increased interest in plastics and reconstructive experiments at St. Michael's Hospital. Finally, the volume of beer and pot consumed per head is on the rise, indicating empirically, on the whole, that the new curriculum leads to greater delinquency, debauchery and degeneration of moral character.

This has been a long article. I hope that when you've read it, you'll do something about it. My best wishes to those who will be writing outdated examinations; bon voyage to those who will be travelling this summer; my sympathies to those of us who will be starting our clerkship after a whole week of holidays. And to everyone a beautiful summer.

Chandru Sajnani, 7T2
President,
Medical Society.

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ASSEMBLY LINE

Secretary's Report to the Auricle

O.M.A.

Since the recent demise of CAMS, negotiations have been in progress between the Ontario Medical Association and the student societies of Ontario medical schools concerning some form of student membership in that association. All societies favour membership beginning in year one with a small membership fee (about $2.50). Anyone interested in further information should contact Miss Helen Batty, Senior External Affairs Rep.

Reorganization of Faculty Government

Pending discussion at the Faculty Council meeting of May 14, 1971 and approval by the Board of Governors of the university, the Council of the Faculty of Medicine (the final governing authority within the faculty) will be reduced in size from about 1100 members to 165 members, 30 of whom will be elected student representatives (20 undergraduate, 10 postgraduate). Under this plan a Faculty Teachers Assembly (composed of all "those with tenure or continuing appointments in the Faculty of Medicine, holding the rank of lecturer, clinical teacher or above") will also be established. They will be meeting at least biannually to approve constitutional changes in the Faculty Council before implementation, to make recommendations to the Council, to consider actions of the Council, and, under exceptional circumstances to vote no confidence in Council. Anyone interested in further details of the plan or its possible implications should buttonhole one of his class representatives.

Self-Teaching

The Division of Studies in Medical Education is planning to organize a self-teaching project in the faculty over the next few years. Phase 1, a pilot project, could be ready for use in the fall of 1971 as floor space (Old Anatomy 313) and the necessary hardware (tapes, projectors, and video equipment sufficient for eight carrels) will be available.

A team with representatives from both the faculty and students will be working over the summer to prepare audio-visual instructional packets in various fields. It is planned that each "packet" will include the necessary core material, a method of self-evaluation, and additional enrichemnt material. Initially these packets would be only supplementary to lectures and labs and would provide an opportunity for review. In Phase 2, the number of carrels would be expanded from eight to twenty-five and in Phase 3 complete systems of topics would be offered to a test group of students as an alternative to the present lecture system.

Help will be needed in getting this idea off the ground. In particular a group of student advisors are required to assist in running the pilot project labs this coming September. This should provide an excellent opportunity for anyone interested in audio-visual instruction to gain valuable experience. An honorarium may be possible. If you are interested in this aspect of the project or any other, contact Dr. J. Parlow in the Division of Studies in Medical Education (Old Anatomy Building), Mr. Michael Ginsberg (Medical Society liaison officer-Meds 7T3), or one of your class representatives.

Orientation

A comprehensive orientation programme is being planned for the incoming class of 7T5. A booklet containing an orientation agenda, course evaluations, information on student activities (Medical Society, sports, etc.), financial aid, eating spots, bookstores etc. will be mailed out at the end of July. On Tuesday, September 7, following registration there will be a formal reception for the incoming class in the Auditorium of the Medical Sciences Building starting at about 9:30 a.m. This will include a welcome from the Dean, a talk by Dr. Steiner explaining the ins and outs of dealing with the Student Affairs Office, a comic interlude (Daffydil's film), an overview of the medical course with emphasis on first term given by a member of the staff, perhaps a similar presentation by a student, and a pitch for other orientation activities by a member of the committee. This will be followed by coffee (tea?) and pastry in the foyer. All members of the Medical Society and faculty are invited to attend. On Saturday, September 11, the morning will be taken up by presentation

of student activities: sports, SHOUT, Daffydil, Arts and Letters, Auricle, External Affairs and anything else available. Again this year the Dean has generously offered his farm as a site for a get-together that afternoon. Various parties are in the works for the following week.

To give the incoming class an overall picture of what they've gotten into and to start them off on the right foot, the participation of all student organizations is requested. Mr. Robert Duggan (7T4, 929-5964) is co-ordinating publicity and is the man to see if you would like to have any material included in the booklet or publicized in some other way. Mr. Robert S. Davies (925-0082) is the chairman of the subcommittee responsible for planning the Saturday programme. For any other information or suggestions concerning the orientation contact Mr. Murray Christianson (921-5311).

Period I Committee

The Period I committee had adopted the Cinader Subcommittee report on Evaluation procedures. This report calls for twelve examinations over the year, each of which can draw on related material in previous courses. For example, for the examination in cardiovascular physiology, the student would be responsible for the anatomy and histology of this system. In case of a failure, optional, remidial classes would be offered on Wednesdays, and an informal assessment would be given when the remedial material was completed. Only if the student failed the informal assessment would he be required to sit for a supplemental examination. Comprehensive examinations would be given as a learning aid, would not be compulsory, and would not be used for administrative purposes. The recommendations of this report have not been approved by the Curriculum and Examinations Committee as yet (May 8) and therefore may not be implemented.

Period II Committee

"The ultimate responsibility is to the self and to the people"

The Period II Committee is one of the several sub-committees of Faculty Council. It is composed of the chairmen of the various Period II systems such as G-I, PMD, Haematology etc., and student representatives from period I and period II. Its natural purpose is to consider

evaluations of the different systems and make appropriate recommendations affecting the course content, staff and students. In this aspect the committee closely co-operates with the Curriculum and Examinations Committee.

The present chairman, Dr. Jack Laidlaw, will be stepping down this year in favour of Dr. Robert Volpe, the present Secretary. Dr. Laidlaw has been a most competent Chairman, untiring and devoted. He has kept the meetings stimulating and exciting and has always been able to bring the salient features of an argument together (no mean feat!).

The consequences of the Period II meetings are obviously most relevant to students of both Period I and II. I would urge all those students who are interested in what's happening, or who have recommendations, to contact their Period II Committee representative(s).

Period II Comm. reps	Ib	Andy Menkes
	IIa	Paula Chalmers
		Joseph Blankier

Period III

Recommendation of the meeting of February 25, 1971:

"That, in the academic year 1972-73, the Department of Family and Community Medicine be allotted a block of two weeks of time, to be used in conjunction with the Department of Preventive Medicine, and to include the teaching of Medical Ethics and Practice, and that the present fifteen half-day sessions throughout the Medical-Surgical term be deleted."

Electives

Elective time is again (still) being threatened by many members of the faculty who feel that students are not using it as it should be used or that too few students are taking proper advantage of the learning experiences available. It is therefore IMPERATIVE that ALL (that means you) students who are taking an elective of any kind (catalogue or self initiated) complete the necessary forms available at the Student Affairs Office.

Awards Sub-Committee

Revised Recommendations for awards to undergraduates based on academic achievement:

"The Sub-Committee on Awards requests that it be granted power to proceed with attempts to modify conditions of awards and prizes to meet the restrictions imposed by the new method of grading, in accordance with the following principles:

1. that no special examinations be held for the purpose of making awards;
2. that, where possible, monetary awards to any one student should not exceet $150 in any one academic year, except for awards made at the end of Period III;
3. that, in the case of awards resulting from open bequests to this Faculty, the conditions be modified so that the award be made on the basis of a ranked list of students attaining Honours standing at the completion of the appropriate segments of the curriculum."

This recommendation will be presented to the Faculty Council Meeting on May 14, 1971. For further detailsoor explanation contact your student representatives on this sub-committee, Mr. Dov Rotenberg, Mr. Jerry Teitel, or Mr. Murray Christianson.

Supplemental Examinations

Carried at a Meeting of the Committee on Curriculum and Examinations, April 27, 1971.

"That the timing of the supplemental examinations be set as close as possible to the commencement of the next academic term, preferably in the last week prior to that commencement."

Murray Christianson 7T4
Acting Executive Secretary.

Evaluations Committee, Medical Society

This committee has a homeostatic function within the body of the New Curriculum. Not having any staff members, this committee functions with unity of purpose, if not of method. The one representative from each year is responsible for the preparation of course evaluations, with the technical guidance (and finance!) of the Division of Studies in Medical Education, which is the Faculty of Medicine's superego. The data obtained from questionnaires serves as a basis for changes in systems/topics. Some courses admittedly adopt more changes than others. Moreover, these evaluation reps may also serve on the relevant Period Committees, providing verbal and immediate feedback. Members also discuss each course with the system's chairman and/or the system's committee, expanding on the course evaluation.data. They answer further questions and make suggestions for improvements. Meetings occur frequently but irregularly, generally when members brush shoulders in the halls of the M.S.B.

Evaluations Committee, Faculty of Medicine
(to be distinguished from the above)

Established by a May 30, 1970 resolution of Faculty Council, this committee is about to hold its first meeting on Monday May 17. The objective of this committee is "to monitor and measure the performance of the curriculum..., in order to assess its effectiveness in terms of the professed philosophy and objectives of the Faculty" (i.e. see calendar). To do this, the committee will be seeking opinions on aims, evaluations and effectiveness of the New Curriculum. The committee actively seeks opinions. Write them out and give them to any of the committee members or leave them in the Medical Society Office. Members of the committee: the Dean (or his representative) as Chairman, 2 undergraduate students (in the persons of Mike Ginsberg, Meds 7T3, and), 2 post-graduate students, 2 staff, 2 alumni (practising physicians not on staff) and a variety of non-voting ex officio members. The committee's final report will recommend modifications of the undergraduate medical programme, emphasizing long-term changes, although modifications of immediate importance may be considered.

So you're here to learn the noble art of Medicine, you're here to be molded (or is it moldered) into a doctor. You're going to lectures, labs, clinics, seminars. The goal is worth the bullshit. Maybe, my dear "colleague". Only maybe.

September, 1970 (exact time not known): a vicious new viral strain escapes from Microbiology lab, M.S.B. and selectively infects 200 Period I students. Virus goes into a four-month incubation period, and is labelled U.C.E.V. #I (Unreasonable Comprehensive Exam Virus #1)

January, 1971: U.C.E.V. #1 fear breaks out among students; student committee formed to investigate, discover weaknesses, and effect cure.

February 17th, 1971: some staff unknowingly join the cause - Meeting, Period I Committee - resolution passed concerning U.C.E.V. #1: that "it should be regarded as an experiment -- we reiterate that this test should not have administrative purposes, but should be presented and dealt with in terms of self evaluation ...". Dum da dum dum .. (Please add appropriate music.)

February 18th: Student Affairs Committee Meeting - exam regulations modified to facilitate Period I recommendation - we forge ahead.

February 23rd: Curriculum & Examinations Committee Meeting - students shafted as the Faculty of Medicine takes a step backward. The only three members of Period I Committee who voted against the "Experimental Comprehensive" are the only three voting members from the Period I Committee who also sit on the Curriculum & Examinations Committee. Curriculum and Examinations rejects Period I recommendation. Dum da dum dum ....

Students riot (not really, they were just severely pissed off). Petition drawn up: contains support for Period I recommendation and the following "Because we will be required for the rest of our medical careers to integrate material we have learned and will learn in future, we recognize the validity of administering an integrative examination. However, since this is the first time a Period I integrative examination will be attempted, we feel that the structure and function of this examination should not be prematurely defined" - U.C.E.V. #1 recoils - cure has been found: logic and reasonable requests. The petition (signed by 184 Period I students) goes to Student Affairs Committee. Dum da dum dum ... dum (high note).

March 18th: Student Affairs refers to Faculty Council with support.

April 2nd: Faculty Council Meeting - approximately 100 students attend to observe what they hope will be the demise of U.C.E.V.#1 - no fireworks - U.C.E.V. #I referred back to Student Affairs and

Curriculum and Examination Committees. Student Affairs adheres to its original support of the petition.

April 27th: Dum da dum dum ... Curriculum and Examinations meets, several student representatives in attendance; the Battle to defeat U.C.E.V. #I was here won, not by students, not by staff, but by pure unadulterated reason (i. e., not a sex crime). Curriculum and Examinations Committee members discussed the theory of Comprehensive exams in depth and in the light of the recommendations of the newly finished Cinador Sub-Committee report (dealing with evaluations of students) voted overwhelmingly to reverse their original decision: "Moved that there be a comprehensive exam at the end of the present Period I in January, 1972, but that this particular exam should be set on an experimental basis and the results should not be used for the assignment of honours, pass, fail standing". There were only three votes against this motion and well over twenty in favour.

Only one more river to cross (reminds me of a song: one more river, and that's the river of Jordan ... the animals came in two by two, etc., not referring to staff as animals, mind you), the river of no return Faculty Council. DUM da DUM DUM.

May 14th, 1971 - the motion of Curriculum and Examiners was presented and passed without so much as a whimper and U.C.E.V. #I died a well-reserved death.

There are eight million stories in the Naked M.S.B., this has been one of them. The names of those involved have been withheld to protect the guilty.

Tune in next year for the next episode in our continuing story of students and staff vs. other Unreasonable Viruses.

Sergeant Friday Ten Four

Rob Duggan 7T4

MEDICAL ATHLETIC ASSOCIATION

The academic year closes with few athletic distinctions, yet there is much that we can be proud of. Hart House has recently released figures which show that Medicine this year has entered seventeen teams which is four more than were entered last year. Further, only two games were defaulted. Although we have completely lost the premedical years from whose ranks we would normally have drawn, we nevertheless managed to provide a total of two hundred and sixty two participants this year, which is slightly higher than last year's total. We are proud of the squash team which won the championship.

Due to structural changes within the academic programme of this faculty, there are only three years in which students can be reasonable expected to participate in athletics. Curriculum changes within these three years have also imposed unfounded fears upon the minds of some prospective athletes. However, many have shown this year that it is possible to cope with the new curriculum and participate in athletics successfully. Indeed, I think that in many cases higher marks were obtained within the period of athletic participation. The years before professional responsibilities are few and precious and we should take advantage of the opportunity to build and maintain strength of body and mind offered by the athletic programme of the University of Toronto. There is a definite need for a substantial athletic programme within this faculty and consequently continued enthusiastic participation from you, the student.

It is ironic to hear students complaining of not being able to meet others within the faculty when the arhletic programme which caters to the average athletic personality (in Foctball, Touch Footbail, Soccer, Rugger, Lacrosse, Squash, Volleyball, Basketball, Hockey, Water Polo, Indoor and Outdoor Track, Swimming and Tennis) offers the obvious opportunity. Exchange of comaraderies, and exam tips as well as course and professorial assessments from each year probably occur more frequently within the locker rooms or in post game libations than any other locus within the medical school.

The athletic session of 1971-1972 promises to be exciting, innovative and in the black. The executive will keep the bulletin boards posted with events and will be looking for your suggestions and vigorous participation as the skull and crossbones are carried to more successful encounters.

David Salter 7T4
(924-7500)

FOR THE PEOPLE

Hopefully, physicians' attitudes in practicing medicine involve the concept that they are dealing with and treating people and not only solving a puzzle.

For this attitude to be realized, a physician must cultivate a capacity to understand and deal with people. It can't be achieved in 2 lectures or a clinical session. It requires a life-time of experience and development of oneself as a person. That is, medicine is people, medicine is life (and death). To be a good doctor, one has to be a good person, an understanding, empathic human being.

Too often, idealistic young people enter medicine with only shallow experience as people, not appreciating what suffering, what love, what life and death really mean. For that matter, some never really come to understand these aspects of being a human being.

* * *

Art is an expression of life and through it a better understanding of people is attained.

The Arts and Letters Society, in recognition of these things, hopes to establish a program which will perpetuate and cultivate existing human qualities as expressed through the arts and hopefully offer opportunities to create new ones in some people.

At present an inventory of cultural interests is being carried out in order to establish a program in which there will be something for everyone to participate in.

Under my chairmanship, the Arts & Letters Society will present or organize at least: 3 folk concerts (May, Sept., Jan.), 2 classical concerts (Nov. and Feb. in the Edward Johnson Bldg.), a photography and an art salon.

Under consideration is the establishment of a Debates Society, a glee club, a literary club and a literary publication.

I encourage and request that anybody interested in working actively to establish and/or participate in any of these activities to contact me.

It is my earnest wish to get as many colleagues as possible involved in these programmes and to provide them with the opportunities to develop themselves further as people and as physicians.

A.R. Osuszek 7T3

"Orthodox medicine has not found an answer to your complaint. However, luckily for you, I happen to be a quack."

THE FORUM

The "Honours, Pass (Fail)" Flail

Last year ranking was dispensed with at this medical school, and in its place the "Honour, Pass(Fail)" system was introduced. The reasons for doing so have been explained to me many times and yet I still don't understand how the new system solves our problems.

In the first place, since exams were not truly representative of the course material, marks based on them were not a true indication of the students' understanding of the course. Furthermore these unrepresentative marks were then used as a criterion for forming a likewise prejudiced rank or standing in the class, which was available to hospitals and employers. The solution wasn't to try to set up a better system of evaluation, but instead, these same exams and marks are now used to rate a student H,P or F, and are still available to all enquirers. A corollary to this new system of evaluation was that, since the difference between someone who stood 13th and 23rd (or between 94th and 103rd) was really almost negligeable (about 1 or 2%, if that much), it would be silly to differentiate between them. This reasoning led to the all-inclusive H or P, which, in theory, negated this difference. In so doing however, it separated the students who stood 23rd and 24th (H & P) far more than ever before. Oh well, you can't make an omellette without breaking any eggs and besides #24 will never know.

Secondly, it was suggested that good academic standing doesn't necessarily mean a person will be a good doctor. This may be true, but in the present system, not only has the distinction not been removed, but the boundaries have been made more rigid. In other words, where you see an H, read 'good academic standing' and where you see a P, read 'fair, average student'. (#24 used to be a good student).

Thirdly, it was feared that there was too much competition with students trying to get a high standing, and too much importance attached to it by the students and the outside world. Also, if you didn't get an A, you knew exactly how you stood in relation to the others, and so did the world. Now you push just as hard for an H, and its just as important, but you never find out how close (or far) you came. Some students would like to know.

There were many other reasons for the switch, but these are the most important ones I've heard. I will now discuss some points and try to show further that not only was no good done by this switch, but that it makes things worse.

Some hospitals, when taking on interns or residents, want to look at their academic standings. Whereas before there was some criterion for doing this via ranking, now there is only H & P. A student tries to get into a hospital which isn't in the U of T hegemony, which requires this, what will he do? I don't foresee any great trouble for those who got an H (unless they want to go to Harvard or John Hopkins), but some of those students who got passes may find that they are very restricted in their choice of out-of-province hospitals. Somebody I was once talking to about this said that perhaps, as time goes on, these hospitals will realize that a Pass from U. of T. means that you're "one hell of a doctor", and therefore our students will be accepted. I tend to doubt this because I feel that those who stand at the tail end of the class, 150 on down, are not as good as those that would have stood 24 to 75 (B_1 to B_{51}). Since no one will ever know the ranking, after a few bad experiences, the hospitals may shut their doors to all P's.

Another reason for believing this is that no-one fails at our school. Is it because we are all so good or is it because "no-one will fail psychiatry IIa because the mean will be so high that everyone passes"? This is the way it is here because Ontario desperately needs doctors, and the government is pressing U. of T. to mass produce M.D.'s under the principle that a bad doctor is better than no doctor. As long as we stay in Ontario this is great. But what if we want to move?

It seems to me that, instead of throwing out the ranking system, it might be better to try to improve the exams so that they are representative of course material, i.e. that the marks and the rankings based on them would mean something concrete vis a vis the student's aptitude for being an M.D. Sure some people would feel bad that they were 109th and someone else was 98th, but that's life--luck as well as brains and personality count.

In conclusion, then, it is my belief that the supposed change-for-the-better in the new system of evaluation is actually a change for the worse. I hope that my criticisms of the latter, which I have presented in this article, will be taken into consideration by the powers that shape our educational destiny.

Robert Moses 7T3

...from the opposition:

How successful has the honours/pass/fail system been in its first year?

First and foremost, the great pre- and post-examination struggle for the almighty mark has come to an end. We have come to realize that 73% and 76% and 78% are much the same after all. The immediate corollary is that when one studies, the pre-examination pressure is decreased, and the freedom and enjoyment somewhat increased.

Learning and studying has become very much less mark-oriented and test-oriented. Instead of studying solely for a test, I find myself studying medicine and liking it much more. The days of memorizing the origin and insertion of anconeus have ended. Tests have become more learning and feedback oriented.

Moreover, in the past, mark-oriented learning left a permanent scar. Like Skinner's pigeons, we learned to perform for a reward--marks. But once out of medical school, there were no more tests and no more marks--and therefore lack of motivation to continuesstudying and learning. The honours/pass/fail system has provided, at least in some small way, some freedom to learn and study for the sake of one's future patients, and it does not discourage continued self-education after graduation. For those who find they require some extra motivation to study, this is provided by simply having a test after each course; whether marks or honours/pass/fail or some other system is used doesn't really matter. Just in passing, let me say that I believe that the motivation that tests provide is artificial--this motivation is no longer present once we are licensed. Furthermore, I do not believe that one's patients provide the sort of motivation needed for continued study either.

Because each of us may check the correct answers, finding where mistakes were made and where weaknesses lay, tests still provide maximum feedback--and this is independent of the grading system. For those who find competition stimulating, herein lies the real competition--the fight to do one's very best. The war to stand 28th in the class, the war to beat your lab partner who got only 77% has ended. Amen. And we are getting close to the real motivation---the desire and determination to do one's very best. If we carry this self-motivation with us, continuing self-education is assured for our patients' emmense benefit.

What about the drawbacks of the honours/pass/fail

system compared to marks? Some suggest that marks are necessary for the proper awarding of scholarships and bursaries. I disagree. The Sub-Committee on Awards has recently proposed a very valid and equitable system of awards (space does not permit me to outline it here). Some suggest it is unfair that those who get "78%" and "79%" (so close to honours) are awarded pass, just as those who get "61%". I cannot disagree. But is it any fairer to say that one person stood 50th and another 90th because one averaged 72.3% and the other 70.4%? No system is perfect. I would personally suggest changing honours/pass/fail to simple pass/fail--you either know enough about subject X to practice medicine or you don't. This would eliminate the stratifying function of testing and emphasize the self-evaluation aspect. Some suggest that since marks are a major criterion which hospitals use to choose interns and residents, we have, by choosing the honours/pass/fail system, jeopardized our chances for the best hospital positions. I agree. But does a 73% in surgery and an 84% in anatomy and a 68% in psychiatry really and truly determine how good an intern or resident you'll be? This time-honoured system is crude and artificial--and inaccurate. Let's hope that other medical schools will join us in abandoning marks and thereby guillotining this archaic system. It's not easy to be a pioneer, you know.

Mike Ginsberg 7T3

FOR YOUR ENJOYMENT

Psychiatry, The Medical Model, and R. D. Laing

"If I could turn you on,
If I could blow your wretched mind,
If I could tell you, I would"

R. D. Laing

Psychiatry today faces a dilemma. The medical model, so sacrosanctly employed by psychiatry since its inception, is beginning to come under question. Psychiatrists are no longer unanimous in how they conceive of their discipline. There are basically two camps (with a spectrum of theoretical models in each one). The first sees psychiatry as a specialty of medicine. As a consequence, psychiatry becomes a discipline like any other specialty of medicine, employing its tools, conceptual models, and general scientific framework. The subject matter of psychiatry, seen in this way, becomes the "pathology" of human behaviour and emotions, its "treatment" and "cure", just as the study of infectious diseases involves the pathology of infections, its treatment and care. According to this camp, the ideal psychiatrist, is the person who has gone through a rigorous scientifico-medical training, has learned the "value" of objectivity in relation to everything he encounters in the world, has acquired a facility in discerning the so-called "signs" and "symptoms" of "disease" or "sickness" in the behaviour of the "patient" whom he deals with as "objectively" as he can (which really means "as an object") and has a thorough knowledge of the "therapies" which can be employed in the "treatment" of the individual patient, in order to relieve his pain. Sociocultural factors relating to the patient's "illness" are taken into consideration, but are usually of secondary importance.

Against this whole current of traditional thinking, a new school of thought has emerged, headed by psychiatrists like R. D. Laing, David Cooper and Thomas Szasz, who see the use of the "disease" model described above as entirely inappropriate in terms of its application to human behaviour. Their basic contention is that if you are dealing with a "science" of persons, whether this be anthropology, sociology, or psychiatry, then the proper subject matter within each one of these sciences is the "person qua person", and not the "person qua object". Since the scientifico-medical model deals with the "person qua object", it is therefore seen as inappropriate to a "science" of persons, in spite of the claim of the scientific psychiatrists, that it is only in viewing the "person qua object" that any

real 'objective' knowledge of the individual is gained. As Laing points out in his first book, The Divided Self, "The clinical psychiatrist wishing to be more 'scientific' or 'objective', may propose to confine himself to the 'objectively' observable behaviour of the patient before him. The simplest reply to this is that it is impossible. To see 'signs' of 'disease' is not to see neutrally!" (1) Thus, according to this camp, 'objectivity' is not only inappropriate, it is impossible. Laing goes on to say that "there is a common illusion that one somehow increases one's understanding of a person if one can translate a personal understanding of him into the impersonal terms of a sequence or system of 'it-processes" (i. e. - "person qua object"). (2) The ideal psychiatrist from this camp's view, is therefore someone who does not approach the person in question (i. e. "the patient") as an entity in which there is an "illness" which must be "cured", that is, as an "object-to-be-changed", but as a "person to be accepted."

The notion that one is not being "neutral" when one "sees" the "signs" of "objectivity" in which the whole scientifico-medical model is shrouded. And yet, it is precisely this cherished objectivity which the psychiatrists of the first camp are unwilling to relinquish, and which accounts for the tenacity with which they invoke the medical model in their practice. Their fear is that psychiatry, in its short history, has already become so metaphysical, that any generalization or theory that arises out of the "data" of its discipline, is so abstruse and abstract, that it cannot, in theory, be falsifiable. This contradicts a necessary condition of any scientific theory.

To explain this concern of the first group of psychiatrists over the "unscientific" status of psychiatry today, we must look back at the philosophical atmosphere out of which the scientific model, as we know it today, grew. Before the Renaissance, events were explained theologically as being "the will of God" or in terms of metaphysical entities which could not be directly observed and were usually anthropomorphic projections of the metaphysician. As a result, many human atrocities were committed "in the name of God," for example, treating the mentally or emotionally disturbed as though they were possessed by devils, and torturing them "for their own good", in order to bring about the exorcism of these satanic beings. It was during the Renaissance that men gradually became aware of these "evils" of metaphysical speculation. The English philosopher David Hume thought, for example, that the metaphysical scriptures of the scholastics

should be thrown into the fire, for they contained nothing but "sophistry and illusion". This statement paved the way for the emergence of "empiricism" which claimed that true knowledge begins in direct observation. This became the philosophy of the day and has continued to be so for the last 200 years. Since empiricism is a philosophy which restricts one to the observable, the empiricist believes that he is being objective. This is the rationale behind the emphasis on empiricism in science, medicine, and the first camp of psychiatry. If the "myth of objectivity" is exposed, however, then the scientific psychiatrist feels that he has nothing certain to cling to, and is therefore once more thrown into the very metaphysical doubt he sought to eradicate. His only defence is, of course, to uphold the scientifico-medical model, even in the face of such exposure by the second camp.

This desire for "certain knowledge", expressed by the scientific psychiatrists, is, in fact, only spuriously satisfied by the scientifico-medical model. Because medical science seems to "work", one is given the impression that it is deductive in nature (i. e. has deductive certainty). For example, one begins to believe that the diagnosis of an infectious disease is a deductive process (i. e. either the patient has the symptoms or he doesn't; if he does, then he has the disease, otherwise not.) Since the conclusion always follows, with certainty, from the premises, in deductive argument, it is easy to understand why people would want to see medical science, as well as science in general, as deductive. The fact of the matter is that science is inductive. All scientific theories and hypotheses are built up from empirical observation and are liable to falsification. No scientific law or theory has deductive certainty or expresses an immutable truth. All that can be said is that we have good inductive evidence for them. Even the principle of determinism (that every event has a cause) which underlies the whole scientifico-medical model, is an a priori assumption of all scientists, and not a provable truth. Any attempt to prove it only results in one's begging the question.

The inappropriateness of the scientific model is explained further by David Cooper, a colleague of Laing's in his book Psychiatry and Anti-Psychiatry. According to Cooper, the scientific model has valid application to the world of objects where there is little interaction between the observor and the object observed, so that the observor's relative place in space and time has only minimal effect

on the things he is observing. However, as regards human beings, there is always an interaction going on between the observor and the observed and therefore a mutual disturbance of their respective reference points. The scientific model does not allow for an analysis of such a dialectical interaction. Since human beings are always interacting, they are always in the process of becoming (i. e. - are never complete) and cannot be grasped or understood in the analytic fashion that the scientific model requires. Also, since human beings are free agents, expectations and predictions regarding their behaviour also become inappropriate.

But the scientific model is more than just inappropriate. Both Laing and Cooper speak of the "violence" that psychiatry perpetrates on the individual, in the name of medical science. We should remember, at this point, the example cited above, where "ill" people were tortured during the medieval period, "in the name of God," to drive out the devil in them. The Church did not feel that its treatment of the "emotionally ill" was any less humane than the treatment given by the scientific psychiatrists of today. We feel we can see the obvious "inhumanity" of the former kind of treatment. Can we allow ourselves to see it in the latter?

If a patient is brought by his family to a mental hospital because he believes that there are people in the world who are trying to kill him, he is seen by the psychiatrist as suffering from "a delusion", "not in his right mind", "in need of treatment" and promptly given a drug which brings about a "remission of symptoms". The psychiatrist of course feels that he has genuinely "helped" his patient. Why the person had this belief in the first place, or what factors in his life were operating to bring about this "delusion" are usually of secondary importance. By using the term "delusion", the patient's experience is totally invalidated, first by the members of his family (who now begin to "understand" the patient's "delusion" as just being "part of his sickness") and then by the medical and psychiatric "authorities" who become merely an extension of the family's point of view. He is treated as an object, in which there is a "sickness" and he is the one who is "diseased", "wrong" and "in need of treatment." It is this kind of invalidation of the patient's experience that constitutes the "violence" of psychiatry.

Both Laing and Cooper have spent time studying the families of so called "schizophrenics." It is their belief that "schizophrenia" in a person can be understood in terms of the dynamics of the interrelationships among the different members of the family. Laing's view of the schizophrenic is better understood in terms of his view of man in general.

He sees normal man as being in a state of "self-alienation". "As adults we have forgotten most of our childhood...as men of the world, we hardly know of the existence of the inner world...our capacity to think...is pitifully limited; our capacity even to hear, see, touch, taste and smell is so shrouded in veils of mystification that an intensive discipline of un-learning is necessary for anyone before one can begin to experience the world afresh, with innocence, truth and love". (4) In the words of the German philosopher Martin Heidegger "the dreadful has already happened". Normal man, says Laing, does not know who he is. He is "a product of repression, denial, splitting, introjection and other forms of destructive action on experience". (5) He is radically estranged from his own being. But "society highly values its normal man. It educates children to lose themselves and to become absurd, and thus to be normal...normal men have killed perhaps 100,000,000 of their fellow normal men in the last fifty years." (6)

Laing explains man's alienation from himself, in terms of a "collusion of interests" (7) in his family of origin. What he means by this can be illustrated by the following: If I, as a child, have the experience that I am not loved, I will be allowed to retain that experience as long as it does not contradict some belief that the family has about itself. In other words, I must collude with the family's interests. Therefore, if my family sees itself as a 'loving' one, I will have to deny my experience of not being loved, and then deny that I have denied not being loved, just in case someone should question me about it. When I grow up, I will have no recollection of ever having felt that way. I will see my family only as a 'loving' one. If I didn't, my experience would be invalidated (i.e. I would be told that I was crazy by my family).

According to Laing, the schizophrenic, in contrast to normal man, is someone who has been "forced into a special strategy in order to live in an unlivable situation". (8) All his bizarre behaviour and "delusions" become intelligible in light of the role he plays in the dynamics of the family. Laing, however, does not look upon schizophrenia as a "break-down" but potentially as a "break-through". "Can we not see that this voyage (i.e. schizophrenia) is not what we need to be cured of, but that it is itself, a natural way of healing our own appalling state of alienation called "normality". (9) The schizophrenic, for Laing, is someone who is far from "deluded". In fact, he may be someone who

has let in light (i. e. - revealing the existential truth of his situation) "which does not enter the intact minds of many sane people whose minds are closed"(10) What we call insantity, then, may be closer to sanity than normality.

I have attempted in this article, to outline a radical approach to psychiatry as espoused by Laing and Cooper. In conclusion, I would just like to say that we as medical students, who have just gone through an intensive course in psychiatry for the last five weeks, should be aware of this rapidly emerging approach in psychiatry, aware of the criticisms that Laing and Cooper make concerning the scientifico-medical model, aware of the atrocities that we may be perpetrating on our fellow man, by our so-called "scientific humanism", aware of the power that is entrusted to us, by virtue of the authority of our medical education, a power that we may use destructively as well as constructively. We must be willing to deal with other persons as persons, and not merely as objects (or (as "patients" or "at a distance") willing to see in ourselves those very psychotic tendencies which we so facilely diagnose in our patients, and be willing to use them in a more honest, real approach to other people:

> "If you take away everything,
> all the clothes, the disguises, the crutches,
> the grease paint, also the common projects,
> the games that provide the pretexts for the
> occasions that masquerade as meetings --
> if we could meet, if there were such a
> happening, a happy coincidence of human beings,
> what now would separate us?"
>
> R. D. Laing

Footnotes

1. R. D. Laing - "The Divided Self" Page 31
2. Ibid - Page 22
3. cf. "The Making of a Counter Culture" by Theodore Roszak, for a fuller account of what the "myth of objectivity" means.
4. R. D. Laing - "The Politics of Experience" - Pages 22-23
5. Ibid - Pages 23-24
6. Ibid - Page 24
7. cf. "The Politics of the Family" by R. D. Laing, Chapters I & II
8. R. D Laing - "The Politics of Experience" - Page 95
9. Ibid - Page 136
10. R. D. Laing - "The Divided Self" - Page 27

Stephen Ticktin, 7T3

I Think Someone Died

I think someone died some years ago.

I paused on the platform though other commuters nudged rush-hour annoyance. That instant I noticed that someone was gone.

I can't find a name or a face or a place--but it must have been a long time ago.

That public school student who's riding right now on the downgoing escalator--perhaps it was then.

Perhaps it was when I clutched my desk's edge and stumbled over names of capital cities.

It was difficult then--recitation.

I think someone died some years ago.

It might have been when Miss Lewis got mad 'cause I cried when she told us dogs don't go to heaven; they decay in the ground.

That toddler there by the newstand; he's angry because she's pulling his harness. Mother wants to go in a different direction.

I used to get angry like that. Once I accused Mom of not loving me. I was just six so she chuckled and told me that all good parents love their children.

I'm almost certain someone died some years ago.

Thank God all those childhood pains are behind me. Now I can give myself fully to really becoming somebody.

I'm doing pretty well too. I'm up for a promotion in eight months!

I admire my boss; we think alike on so many topics. Just yesterday somebody remarked that a lot of our mannerisms are the same.

That's not strange though. I often try to mimic traits of people I respect. That way, I can become a distillation of the best of many people.

Someone must have died some time ago.

Perhaps if someone hadn't died I might have tried being like him.

Marion Hutt

(The following extract is from a paper which appeared in the British Journal of Psychiatric Reviews, October 1924. It is entitled, Mental Health and the Artist and was written by Sir Arthur Miltown, D.M., PLD.(Hon. Causa; Edin.) Sherrington Professor of Psychiatry, King's College, Cambridge.)

"An Organic Cause of Schizophrenia"

"The fine line between insanity and genius is often neither fine nor a line and it has been said that if someone were to exchange the residents of Parliament of the Royal Society with those of Bedlam Hospital, no one would be aware of the slightest difference."

"A cutting remark, perhaps, but such a case in point is that of the little known statesman, poet and contemporary of Milton, Sir David Huntington-Choria (5th Earl of Leemington). History records (1) that Sir David was perfectly normal, except for a peculiar habit of writing obscene phrases on the walls of the Commons' toilets, until age thirty-five. At this time, the unfortunate Earl was severely criticized by his mistress for a group of poems which he had dedicated to her. Had the incident not occurred during copulation, it is most probable that Sir David may have risen even to the very position of Prime Minister."

"However, some well-founded research into the incident by the late Hugh Hornier (2) maintains that the calumnious stroke of criticism, coming at such an intimate and excitable instance precipitated in Sir David a berry aneurysm from which he never fully recovered all his faculties."

"The Earl's subsequent behaviour caused him to be confined to the basement of the family residence on the Heathmuir Moor, near Cambridge, where he spent the remainder of his days in seclusion, suffering from an illness not unlike that of paranoid schizophrenia (3)".

"Recent excavation at the ruins of the old estate has uncovered several pages of poetry written by Sir David. However, chemical analysis has also revealed that the pages were severely soiled by faecal matter, which also helped to preserve them..The works have been restored in their entirety and were recently displayed at the British Museum in the exhibition,

"Seventeenth Century Paper and its Uses"

"As far as can be determined, the following is the original text of an unnamed poem written by Sir David around 1650."

"Would that I could deceive a nail,
My Hammer'd brain's blankness no longer a bleat
No longer the fettered falsities of a mindless gaol
But whispered whimsicals of mistresses in heat!"

"Sweet death engulf you, bitches, mongrels and cows!
Lest your diseases displeases to chase the unpassionate
pox
Love's silent stream sounds around the silken sow's
Ear--and clamps the menial muzzle upon the feeding fox! "

"The brain's bells knell aloud anew
Each foristy will tropsy and labour inslide
To chide the childless child without curfew
No trinkles are wroppists and terrors confride! " (4)

References:

(1) "The Grief of My Son" in Memoirs, by Sir James Huntington-Choria, Serax Publishing House, London, England.
(2) "Schizophrenia and Poetry in 17th Century England", Hugh Hornier, Ph.D., Annals of British Healing Arts, 324, 75, 1924.
(3) Ibid
(4) A complete analysis of this and other poems of Sir David Hunting-Choria appears in Chapter 5 of "Insanity and Obscure Poetry of English Speaking Countries", John Sparine, Doublebind and Co. Publish. NYC.

I Fell Asleep---i awoke

Yesterday, I fell asleep in the classroom,
and dreamt that Mortal Men were gods.
i forgot that all mankind are children
in the Kindergartens of the Lord.

plagiarized by michael barry ginsberg

ON THE CARDIOVASCULAR SYSTEM

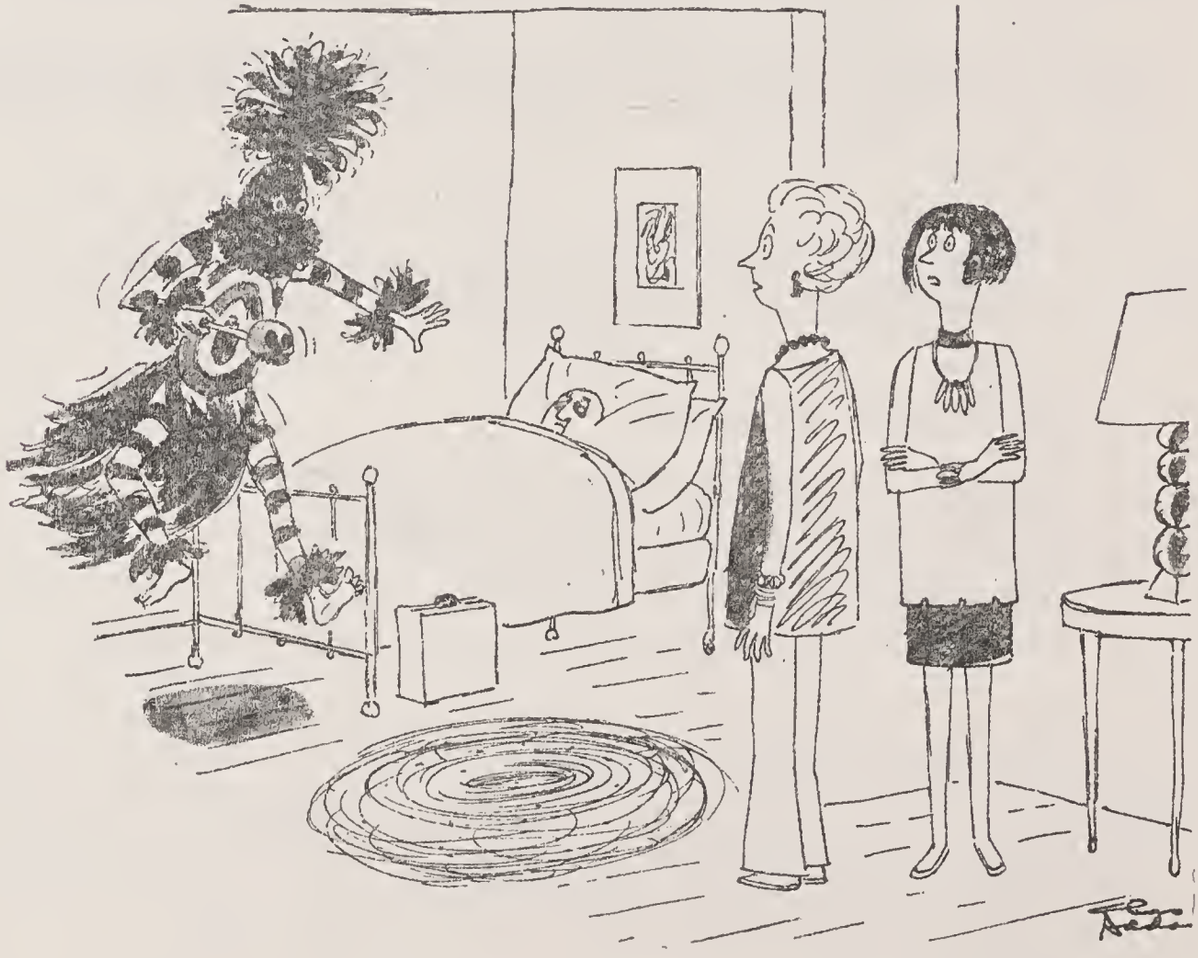
When you said that blood moves in a circle,
my dear Harvey, did you consider
how many medical student's heads
would go 'round and 'round
trying to see?

Ardas Kuraishi 7T4

The Mountain

No gas--no steel--no nuts, no bolts---
Unelectric
You allowed--unmotorized.
You--noisier than all Nature
The ground squirrel squeal-laughs at you, alien.
You trip onward up the Mountain's path.
Soom your loud clumsiness is drowned by the music of
Glacier water icily dashing down the Mountain's slope
Drink this chilled nectar--freezing awakening:
The Glacier flees from the Mountain.

michael barry ginsberg



"At least he makes house calls."

THE DEAN SHOOTS

TECHNOLOGY: MASTER OR SERVANT.

Eyes have they but they see not,
They have ears but they hear not,
They have mouths but they speak not,
They have minds but they reason not,
They have hearts but they care not.
(With apologies to Psalms 115
and 135)

Many of the students who fail in the final years in medical school and in the examinations of the Royal College of Physicians and Surgeons do so because they neglect to use the basic senses with which they are equipped. Practitioners fail to make a correct diagnosis not because they lack knowledge but because they neglect to take an adequate history and to examine the patient thoroughly.

Most illnesses can be diagnosed by the practitioner in his office if he has developed skills in the use of all his senses and performs a few simple tests. He must then analyse and integrate the results in his own mind, the most ingenious computer ever designed. However, this computer, like the mechanical one, will fail if the information it receives is faulty. Adequate, appropriate and accurate information must comprise the input if the output is to solve the patient's problem.

Taking a rambling history with no focus on significant complaints particularly when coupled with a superficial examination is poor and dangerous practice. Ordering a shot gun blast of chemical, radiologic and electronic tests indiscriminately aimed in the vague hope that somewhere in the kaleidoscope of results a diagnosis will be revealed, is further folly. Nature is governed by strict physical, chemical and biological laws and reveals her secrets to those who seek them logically.

Only when history and physical examination indicate that further definitive information is needed should the physician invoke the assistance of specific technology,

and progress from one level of sophistication to the next only when in his considered judgment further refinement is clearly indicated by preceding evidence.

Medical literature is strewn with the case histories of patients labelled as psychosomatics who have died of undiagnosed organic disease and case histories of unidentified psychoneurotics subjected to innumerable operations for imaginary diseases. The fault lay, all too frequently, with the doctor who failed to use his eyes, his ears, his tongue and his hands; with the doctor who failed to elicit the proper input and failed to process it logically and with the doctor who relied on inappropriate technology to take the place of conscientious concerned care.

A.L. Chute, M.D.
Dean